STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6015473	A. BUILDING: _____ B. WING _____	10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ILLINOIS VETERANS HOME AT QUINCY	1707 NORTH 12TH STREET QUINCY, IL 62301

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure	S 000		
S9999	Final Observations STATEMENT OF LICENSURE VIOLATIONS: Section 340.1440 b) Section 340.1440 e) Section 340.1440 Abuse and Neglect b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator. (Section 3-610 of the Act) e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or disciplinary action against the employee. (Section 3-611 of the Act) This REGULATION is not met as evidenced by: Based on interview and record review the facility failed to immediately report an allegation of physical abuse to the facility administrator and failed to immediately remove an alleged perpetrator of abuse from direct resident care. This failure had the potential to affect two of four residents (R2, R5) reviewed for abuse in the sample of nine and 54 residents (R14 through	S9999		

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S9999	Continued From page 1	S9999		

R67) on the supplemental sample.

Findings include:

The facility's Abuse Prevention, Reporting, and Investigation policy dated 07/15 documents, "2. Any staff who observe or suspect abuse MUST report it immediately to their immediate supervisor." This policy also documents, "If there is reasonable cause to believe abuse occurred, an employee accused of resident abuse will be removed from resident contact immediately."

The facility's Incident Report form dated 5/09/17 at 5:50 AM documents, "(R5) reported to me (E4, Licensed Practical Nurse) that the other girl (E5, Certified Nurse's Aide) was a little rough this morning, she pulled my arm down to the handle and she makes me dress myself." This report also documents, "I (E4) told (E5) to be more gentle with (R5) and told (E5) what (R5) had told me (E4). (E5) says that's not right. I didn't. (R5) is just milking this for all it's worth."

The facility's Investigative Report dated 5/10/17 documents, "On 5/9/17 at 5:50 AM, (R5) reported to (E4) that another employee (E5) had been rough with (R5) during (R5's) care that morning. At 7:25 AM, (E4) reported this to (E6, Public Service Administrator)." This report also documents, "(R5) was interviewed in (R5's) room for privacy. (R5) reported that while (E5) was assisting (R5) to the bathroom, (E5) grabbed (R5) by the wrist and pushed (R5's) hand toward the grab bar for the toilet, (R5) stated that it smarted a little. (R5) also stated (E5) was trying to make (R5) go faster. (E5) almost made me fall. It didn't hurt, but it smarted. (R5) also stated at breakfast (E5) announced that (E5) won't be taking care of me anymore. (R5) reported feeling angry that

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S9999	Continued From page 2 (E5) had done this." On 10/11/17 at 9:30 AM, E6 (Public Service Administrator) stated R5 is alert and oriented. E6 stated that she was called by E4 on 5/9/17 at 7:20 AM to report that R5 stated E5 was rough during cares. E6 stated the incident happened at 5:50 AM. E6 stated that E5 continued to work after R5 made the allegation at 5:50 AM. E6 stated E4 should have called her immediately after the report was made by R5 and that E5 should have been removed from direct resident care immediately after the allegation was made. E6 also confirmed that after E4 was made aware of R5's allegation, E4 went into the dining room and spoke to R5 about the allegation. On 10/12/17 at 10:34 AM, E2 Director of Nursing stated E5 could have had direct resident contact with R2, R4, and R14 through R67 on 5/9/17 after R5 made the allegation against E5. (B)	S9999		